Before the
Administrative Hearing Commission
State of Missouri

OZARKS MEDICAL CENTER,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 12-0140 SP
	)	
DEPARTMENT OF SOCIAL SERVICES, MO HEALTHNET DIVISION,	)	
	)	
	)	
Respondent.	)	

DECISION

Ozarks Medical Center ("Ozarks") is subject to $7,782 in recoupment.

Procedure

Ozarks filed its complaint on January 25, 2012. The Department of Social Services, MO HealthNet Division, (the "Department") filed its answer on February 24, 2012. We held a hearing on March 13, 2013. Joshua Brown represented Ozarks. Assistant Attorney General Matthew Laudano represented the Department. This case became ready for decision on June 13, 2013, when the last written argument was filed.

Evidentiary Issues

This case turns on whether Ozarks submitted proper billing codes in claims submitted to the Department for Medicaid reimbursement. At the hearing, during its cross-examination of the Department's witness, Ashley Bates, Ozarks proffered Exhibit 2, a document purporting to

be the 1997 Documentation Guidelines for Evidence and Management Services (the "1997 Guidelines") published by the Centers for Medicare and Medicaid Services. The Department objected to the admission of the document for lack of foundation, and in its voir dire of Bates, established that she was unfamiliar with Ozarks' Exhibit 2.[1] We deferred ruling on the Department's objection, and asked the parties to present their arguments regarding admissibility of Exhibit 2 in their post-hearing briefs.

Admissibility of a document such as the purported 1997 Guidelines is addressed in § 536.070(9),[2] which provides:

> Copies of writings, documents and records shall be admissible without proof that the originals thereof cannot be produced, **if it shall appear by testimony or otherwise that the copy offered is a true copy of the original**, but the agency may, nevertheless, if it believes the interests of justice so require, sustain any objection to such evidence which would be sustained were the proffered evidence offered in a civil action in the circuit court, but if it does sustain such an objection, it shall give the party offering such evidence reasonable opportunity and, if necessary, opportunity at a later date, to establish by evidence the facts sought to be proved by the evidence to which such objection is sustained[.]

(Emphasis added.) Bates' admitted lack of familiarity with Exhibit 2 provides no assurance that it is a true copy of the 1997 Guidelines. Her testimony, therefore, is an inadequate foundation for its admissibility under § 536.070(9).

In a second attempt to lay a foundation for Exhibit 2, Ozarks' sole witness, clinic director Aimee Jarrett, testified that Exhibit 2 came "straight from CMS. This is the initial document that CMS Medicare/Medicaid asked us to use."[3] Jarrett identified Exhibit 2 as the 1997 Documentation Guidelines. Again, the Department objected on grounds that Jarrett's testimony lacked adequate foundation. We agree.

[1] Tr. 72.
[2] RSMo Supp. 2013. Statutory references are to RSMo 2000 unless otherwise noted.
[3] Tr. 125.

The testimony of a witness must be based upon knowledge.[4] Given the limited evidence in the record, we are not persuaded that Jarrett had sufficient knowledge of coding and the pertinent regulations to testify competently about the 1997 Guidelines. Jarrett testified that she earned an MBA in health care administration, but was, by her own admission, not a certified coder; moreover, there was no evidence Jarrett played any role in coding claims. We find her testimony lacked adequate foundation to establish that Exhibit 2 was a true copy of the 1997 Guidelines, and we sustain the Department's objection.

Ozarks made a final attempt to salvage Exhibit 2 by endeavoring to establish through Jarrett's testimony that the 1997 Guidelines were referred to and incorporated in the Current Procedural Terminology code manual ("CPT") used by the Department. Excerpts of the CPT were contained in the Department's Exhibit F, which was admitted into evidence without objection. The Department objected to Jarrett's testimony because it was not the "best evidence" of whether this reference exists in the CPT. When Ozarks conceded that Exhibit F did not include the passages containing such reference(s) to the 1997 Guidelines, we allowed Ozarks to supplement the record following the hearing with those specific passages from the CPT, subject to the Department's opportunity to lodge any objections to that submission. We specifically noted the Department's objections to Jarrett's testimony would not be waived.

The relationship between the CPT manual and the 1997 Guidelines is of critical importance; it is not evident from either document, or from any other exhibit admitted into evidence, whether the 1997 Guidelines are applicable or have been superseded. Yet Ozarks declined to take advantage of this opportunity to supplement the record. Accordingly, the Department's objection to Jarrett's testimony on this point is sustained. We make no finding that the CPT incorporates or references the 1997 Guidelines. Without any connection made between

[4] *Cummings v. Tepsco Tennessee Pipe & Supply Corp.*, 632 S.W.2d 498, 500 (Mo. App. E.D., 1982), citing *State v. Dixon*, 420 S.W.2d 267, 271 (Mo. 1967).

the 1997 Guidelines and the CPT, or competent testimony identifying and establishing the applicability of the 1997 Guidelines to the facts at issue here, we must conclude Ozarks' Exhibit 2 is irrelevant and without probative value. Considering both the testimony of Bates and Jarrett, we conclude an insufficient foundation was laid for Ozarks' Exhibit 2, and we sustain the Department's objection to exclude it from the record.

Findings of Fact

1. The Department is an agency of the State of Missouri charged with administering Missouri's Title XIX (Medicaid) program, and its MO HealthNet Division (the "Division") administers payments under the program. The Division has authority for determining Medicaid reimbursement.[5]

2. The Division has authority to determine Medicaid reimbursement, to determine provider participation in Medicaid, and in administering sanctions, including assessing overpayments and termination against providers who violate the rules of the Missouri Medicaid program.[6]

3. The Division, pursuant to 42 CFR 456.1 through 456.23, is responsible for conducting post-payment reviews of claims submitted by Medicaid service providers.

4. The Department is required to adhere to the provisions of the federally-approved Missouri Medicaid State Plan and must take appropriate steps to assure appropriate and sufficient care for Medicaid recipients, compliance with Medicaid program rules, and appropriate Medicaid reimbursement.[7]

[5] Sections 208.152 (Cum. Supp. 2008), 208.153, and 208.201.
[6] Sections 208.152 (Cum. Supp. 2008), 208.153, and 208.201; 13 CSR 70-3.020, 13 CSR 70-3.030, 13 CSR 70-3.130.
[7] Sections 208.152, 208.153, and 208.201.

5. The Department has authority to require providers to: enter into provider agreements, keep records necessary to disclose the extent of services provided, and furnish any of the information maintained to the Division upon request.[8]

6. At all relevant times, Ozarks was enrolled as a MO HealthNet rural health clinic services provider, and provided services through the Shannon County Medical Clinic (the "Clinic"). Located in Winona, Missouri, the Clinic is the only medical services provider within ten to twelve miles.

7. The provider agreement Ozarks signed with the Department requires Ozarks to abide by the terms of the state Medicaid program, as monitored by the Department, and maintain records of all services provided. At all relevant times, the provider agreement was in full force and effect and binding upon Ozarks.

8. Under the Medicaid program, the provider performs services covered by Medicaid, and then bills Medicaid after the services have been allegedly performed. The Department pays the provider for the services billed, but also performs post-service audits to determine whether the services were performed and properly documented.

9. If there is no documentation of the services billed by the provider, or if the provider's documentation of the services is inadequate, the Department may recoup the money it paid the provider for those services, or may impose other sanctions.

10. A provider filing a claim for payment is required to identify the type of service provided by its appropriate medical billing code, called the Current Procedural Terminology ("CPT") code. The medical billing codes are found in the CPT codebook published by the American Medical Association.

[8] 42 CFR 431.107; 42 CFR 484 *et seq.*

11. The CPT code on the claim tells the Department the level of reimbursement to be paid to the provider. The assignment of an inappropriate CPT code on a claim may result in an overpayment of Medicaid reimbursement to a provider.

12. On October 12, 2011, the Department randomly selected Ozarks for a review of its MO HealthNet records for services provided at the Clinic between October 1, 2010, and September 30, 2011. It requested Ozarks to provide medical records and documentation for a number of Medicaid recipients, as well as the Clinic's fee schedule, for examination.

13. The Department's employee, Ashley Bates, conducted the review. Bates had been a registered nurse for six years, and was certified as a professional CPT coder in October, 2012.

14. Following her review of the records the Clinic provided, Bates noted a pattern suggesting Ozarks had "upcoded" certain claims, because the supporting documentation indicated Ozarks should have billed for its services at a lower level. To further investigate, Bates expanded the audit and requested that Ozarks provide additional records in an on-site visit.

15. On December 12, 2011, Bates visited the Clinic and collected from Ozarks the records she requested on additional patients.

16. While at the Clinic on December 12, Bates obtained the signature of Susan Lindsay, Ozarks' supervisor there, on a billing checklist and on a documentation disclosure statement. The latter document affirmed that Lindsey, on behalf of Ozarks, understood that she was "requested to disclose all documents supporting billings submitted to [MO HealthNet Division] or its agents for services billed for these [reviewed] claims and/or [reviewed] participants in their entirety, including [the] [e]ntire participant/client file," as well as "[m]edical records including treatment plans, progress notes, assessment documentation, etc."[9] Lindsay also acknowledged by her signature on the document disclosure statement that she had "produced all records, in their

[9] Respondent's Ex. C.

entirety, to the above state agency as required by 13 CSR 70-3.030(3)(A)(4)," and that she was "authorized to sign this document on behalf of [Ozarks]."[10]

17. Bates took the records back to her office, scanned them, and then returned them to the Clinic. After completing her review of these documents, Bates issued a final decision letter on behalf of the Department (the "decision letter"), dated January 5, 2012.

18. The decision letter stated Ozarks had received $12,639 in overpayments for claims submitted. Attached to the decision letter as Exhibit A is a listing of all the errors cited, identifying each type by error letters A through H. [11] Also attached to the decision letter as Exhibit B is a claim-by-claim breakdown of each error by type.

19. The decision letter listed 187 "A" errors, 10 "B" errors, 25 "C" errors, 2 "D" errors, 2 "E" errors, 4 "F" errors, 1 "G" error, and 10 "H" errors.

20. Ozarks filed its complaint with this Commission on January 25, 2012 to appeal the Department's final decision.

The Billing Codes at Issue

21. In its review of the Clinic's records, the Department referred to the CPT codebook and to the CPT evaluation and management codes and guidelines for 2010 and 2011.

22. In preparing its claims, Ozarks relied on the 1997 Guidelines, which Ozarks believed supplemented the CPT codebook.[12]

23. The Department did not instruct Ozarks to utilize or rely on the 1997 Guidelines in coding claims for payment.

[10] *Id.*

[11] Petitioner amended its complaint in the hearing to exclude any challenge to Type G or H errors. Tr. 54-55. Additionally, in Petitioner's Exhibit 1, which we received in evidence, Petitioner withdrew its appeal as to Type D, E, or F errors. Thus, no factual findings were made as to errors D, E, F, G, or H.

[12] As noted above, we sustained the Department's objection to the admissibility of Ozark's Exhibit 2, the 1997 guidelines. We note here only that Ozarks relied on the document in preparing claims submitted for reimbursement.

The Type "A" Errors

24. As used in the decision letter, a Type "A" error indicated Ozarks did not have sufficient documentation to support CPT billing code 99214. Billing code 99214 refers to an office or outpatient visit containing at least two of the following three components: a detailed history, a detailed exam, and medical decision making of moderate complexity.[13]

25. The CPT defines a "detailed history" as "extended history of present illness; problem pertinent system review extended to include a limited number of additional symptoms; **pertinent** past, family, and/or social history **directly related to the patient's problems.**"[14] A detailed history must include at least two of the three types of pertinent histories listed in the definition.

26. The CPT defines a "detailed exam" as one that includes "[a]n extended examination of the affected body area(s) and other symptomatic or related organ system(s)."[15]

27. The CPT does not define "medical decision making of a moderate complexity." Instead, the CPT states that:

> [m]edical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:
>
> - The number of possible diagnoses and/or the number of management options that must be considered;
> - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be considered;
> - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed[.]

28. In contrast, CPT code 99213 represents an "[o]ffice or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 components:

[13] Resp. Ex. E at 12; Resp. Ex. F at 8.
[14] *Id.* .
[15] Resp. Ex. E at 9, Ex. F at 9.

- an expanded problem focused history;
- an expanded problem focused examination;
- medical decision making of low complexity."[16]

29. The CPT defines an "expanded problem focused history" as one that includes a "[c]hief complaint; brief history of present illness; problem pertinent system review."[17]

30. An "expanded problem focused examination" is defined in the CPT as one that includes "[a] limited examination of the affected body area or organ system and other symptomatic or related organ systems."[18]

31. In the 187 claims reviewed by the Department and identified as Type "A" errors, Ozarks' records failed to show it provided services consistent with CPT code 99214, but the services were, in fact, consistent with CPT code 99213. Some of Ozarks' records failed to establish a detailed history or medical decision making of moderate complexity, reflecting an improper consideration of the CPT's three factors for determination of medical decision making complexity. For example, some records showed only a limited number of diagnoses or management options, suggesting a lower level of complexity more consistent with CPT code 99213. Other records failed to show a pertinent history directly related to the patient's problems.

32. Each of Ozarks' 187 Type "A" errors identified by the Department represented an overpayment to Ozarks of $39 because of the improper upcoding of the claims from CPT code 99213 to 99214.

Type "B" Errors

33. As used in the Department's decision letter, a Type "B" error indicated claims for which Ozarks lacked sufficient documentation to support CPT code 99215, designated for an office or outpatient visit containing at least two of the following three components: a

[16] Ex. E, 12; Ex. F, 12.
[17] Ex. E, 9; Ex. F, 9.
[18] *Id.*

comprehensive history, a comprehensive exam, and medical decision making of high complexity.[19]

34. A "comprehensive" examination is defined in the CPT as "a general multisystem examination or a complete examination of a single organ system."[20]

35. The CPT defines "high complexity" as "extensive … diagnoses or management options," an "extensive … amount and/or complexity of data to be reviewed," and a "high … risk of complications and/or morbidity or mortality."[21]

36. In the ten claims reviewed by the Department and identified as Type "B" errors, Ozarks' records failed to show it provided services consistent with CPT code 99215, but were, in fact, consistent with CPT code 99213. Some of Ozarks' records lacked a complete family medical history, or social history. Others showed only a low complexity of medical decision making. None of the ten claims reflected a comprehensive examination.

37. Each of Ozarks' ten Type "B" errors identified by the Department represented an overpayment to Ozarks of $80 because of the improper upcoding of the claims from CPT code 99213 to 99215.

Type "C" Errors

38. As used in the Department's decision letter, a Type "C" error indicated Ozarks had no documentation to support the services billed at the time of the review.

39. Of the sixteen claims designated as error type "C" by the Department, Ozarks produced only one record requested during the review, for patient J.L./J.V. Records for the remaining fifteen claims were presented by Ozarks at the hearing.

[19] Resp. Ex. E at 12; Resp. Ex. F at 8.
[20] Resp. Ex. E at 9; Resp. Ex. F at 5.
[21] Resp. Ex. E at 10; Resp. Ex. F at 6.

40. Ozarks' medical record for patient J.L./J.V. indicates the patient was seen for low back pain on November 18, 2010, for which Ozarks was reimbursed $20.

41. Ozarks was reimbursed $1,585 for the fifteen "Type C" claims (not including J.L/J.V.) for which it failed to produce supporting documentation in response to the Department's request.

Admitted Billing Errors

42. Ozarks admits that billing errors occurred in the 111 following instances:

Patient	Procedure Code	Date of Service	Error	Overpayment
A.L.	99203	12/6/2010	C	116
A.L.	99214	7/11/2011	A	39
J.A.	99214	12/28/2011	A	39
J.A.	99213	5/9/2011	D	16
J.A.	99213	7/26/2011	E	0
J.A.	99213	9/23/2011	E	0
Z.B.	99214	4/25/2011	A	39
A.B.	99214	4/15/2011	A	39
J.B.	99214	1/31/2011	A	39
J.B.	99214	8/25/2011	A	39
K.B.	99213	8/18/2011	E	0
E.B.	99214	5/5/2011	A	39
K.B.	81003	11/30/2010	C	17
N.B.	99214	1/31/2011	A	39
N.B.	99214	6/6/2011	A	39
N.B.	99214	8/9/2011	A	39
A.B.	99214	1/31/2011	A	39
K.B.	99214	6/1/2011	A	39
M.B.	99214	4/4/2011	A	39
M.B.	99214	5/25/2011	A	39
A.B.	99213	8/4/2011	E	0
A.B.	99214	8/23/2011	A	39
K.B.	99214	2/3/2011	A	39
S.B.	81025	6/9/2011	F	0
J.B.	99211	10/1/2010	C	38
J.B.	99211	10/8/2010	C	38
J.B.	99211	10/14/2010	C	38
J.B.	99211	10/21/2010	C	38

J.B.	99213	10/28/2010	F	0
J.B.	99211	11/4/2010	C	38
J.B.	99211	11/11/2010	C	38
J.B.	99211	11/18/2010	C	38
J.B.	99211	11/30/2010	C	38
J.B.	99215	12/3/2010	B	154
D.B.	99214	6/27/2011	A	39
D.D.	99214	8/23/2011	A	39
L.D.	99214	6/17/2011	A	39
L.D.	99214	7/13/2011	A	39
R.F.	99215	5/4/2011	E	0
K.F.	99214	4/20/2011	H	55
N.H.	99214	5/10/2011	A	39
N.H.	99214	7/6/2011	A	39
J.I.	99214	2/25/2011	H	55
J.I.	99214	4/25/2011	H	55
J.I.	99214	6/27/2011	H	55
C.J.	99214	5/5/2011	A	39
C.J.	99214	8/22/2011	A	39
H.K.	99214	1/17/2011	A	39
T.L.	99214	2/8/2011	E	0
J.L.	99213	10/1/2010	F	0
J.L.	99213	10/7/2010	F	0
J.L.	99214	1/6/2011	A	39
J.L.	99214	2/28/2011	A	39
J.L.	99214	8/25/2011	A	39
C.M.	99204	6/15/2011	G	63
C.M.	99214	8/17/2011	H	55
J.M.	99214	3/30/2011	E	0
J.M.	99214	3/23/2011	A	39
K.M.	99203	10/6/2010	C	116
K.M.	99214	2/15/2011	A	39
A.N.	99211	10/6/2010	C	40
A.N.	99211	10/14/2010	C	40
A.N.	99211	10/21/2010	C	40
A.N.	99211	10/28/2010	C	40
A.N.	99211	11/4/2010	C	40
A.N.	99211	11/11/2010	C	40
A.N.	99211	11/18/2010	C	40
A.N.	99211	11/23/2010	C	40
A.N.	99211	12/3/2010	C	40
A.N.	99213	12/8/2010	F	0
A.N.	99211	12/22/2010	C	40

A.N.	99211	12/29/2010	C	40
A.N.	99211	1/13/2011	C	40
A.N.	99211	1/28/2011	C	40
A.N.	99211	2/3/2011	C	40
A.N.	99211	2/18/2011	C	40
A.N.	99211	3/3/2011	C	40
A.N.	99211	3/9/2011	C	40
A.N.	99211	3/16/2011	C	40
A.N.	99211	3/24/2011	C	40
A.N.	99211	3/30/2011	C	40
A.N.	99211	4/7/2011	C	40
A.N.	99211	4/13/2011	C	40
A.N.	99211	4/20/2011	C	40
A.N.	99211	4/29/2011	C	40
B.N.	99214	3/14/2011	H	55
B.N.	99214	6/13/2011	H	55
B.N.	99214	7/15/2011	H	55
M.P.	99214	10/1/2010	A	39
M.P.	99214	2/11/2011	A	39
G.P.	99214	2/10/2011	A	39
G.P.	99214	8/17/2011	E	0
I.R.	99214	1/28/2011	E	0
I.R	99214	6/24/2011	C	115
L.R.	99214	7/25/2011	A	39
M.R.	99214	1/24/2011	E	0
M.R.	99214	5/26/2011	A	39
C.R.	99213	4/29/2011	D	16
C.R.	99214	7/8/2011	H	55
C.R.	99214	5/23/2011	H	55
T.S.	99214	3/31/2011	A	39
S.S.	99214	6/30/2011	A	39
E.S.	99214	11/11/2010	A	39
E.S.	99396	11/16/2010	F	0
E.S.	99214	3/30/2011	A	39
S.V.	99214	8/19/2011	A	39
B.W.	99214	3/30/2011	A	39
B.W.	99214	8/24/2011	A	39
R.W.	99214	6/8/2011	A	39
R.W.	99214	6/27/2011	A	39
R.W.	99214	7/11/2011	A	39

43. The Department overpaid Ozarks $4,221 based on these billing errors.

Claims the Department Does not Pursue

44. Bates determined in her report that the following errors occurred:

Patient	Procedure Code	Date of Service	Net Pay	Error	Overpayment
M.S.	99214	3/17/2011	115	C	115
M.S.	99214	4/11/2011	115	C	115
M.S.	99214	5/23/2011	115	C	115
M.S.	99214	8/1/2011	115	C	115
M.S.	99214	8/11/2011	115	C	115

45. Bates initially determined these were type "C" errors because there was no documentation.

46. The Department conceded that documentation exists for these claims, and that Ozarks provided the documentation to the Department at the time of the Department's request.

47. The Department properly paid Ozarks $575 on these claims.

Conclusions of Law

We have jurisdiction over this appeal. § 208.156.5. The Department's answer provides notice of the basis for imposing sanctions.[22] We have discretion to take any action the Department could have taken, and we need not exercise our discretion in the same way as the Department.[23]

Ozarks has the burden of proof and must prove its case by a preponderance of the credible evidence.[24] This Commission must judge the credibility of witnesses, and we have the discretion to believe all, part, or none of the testimony of any witness.[25] Our findings of fact reflect our determination of the credibility of witnesses.

[22] *Ballew v. Ainsworth*, 670 S.W.2d 94, 103 (Mo. App. E.D. 1984).
[23] *Dep't of Soc. Services v. Mellas*, 220 S.W.3d 778, 782-783 (Mo. App. W.D. 2007).
[24] Section 621.055, *Harrington v. Smarr*, 844 S.W.2d 16, 19 (Mo.App., W.D. 1992).
[25] *Harrington*, 844 S.W.2d at 19.

The Department contends Ozarks is subject to sanctions for violations of 13 CSR § 70-3.030(3)(A)4, 7, 28, and 40:

> 4. [S]ervices billed to the MO HealthNet agency that are not adequately documented in the patient's medical records or for which there is no record that services were performed shall be considered a violation of this section. … failure to keep and make available adequate records which adequately document the services and payments shall constitute a violation of this section and shall be a reason for sanction [;]
>
> *****
>
> 7. Breaching of the terms of the MO HealthNet provider agreement [or] any current written and published policies and procedures of the MO HealthNet program … or failing to comply with the terms of the provider certification on the MO HealthNet claim form;
>
> *****
>
> 28. [B]illing a higher level of service than is documented in the patient/client record;
>
> ******
>
> 40. Failure to submit proper diagnosis codes, procedure codes, billing codes regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the MO Health-Net claim[.]

The Department requires providers to generate and retain records necessary to disclose the extent of services rendered to Medicaid recipients. 42 CFR § 431.07. Providers are required to maintain "adequate documentation" to support its claims, defined by 13 CSR 70-3.03(2)(A) as:

> *... documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.* "Adequate medical records" are records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis, and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered. An adequate and complete patient record is a record which is legible, which is made contemporaneously with the delivery of the service, which addresses the patient/client specifics, which include, at a minimum, individualized statements that support the assessment or treatment encounter, and shall include documentation of the following information:

> 1. First name, last name, and either middle initial or date of birth of the MO
> HealthNet participant;
> 2. An accurate, complete, and legible description of each service(s) provided;
> 3. Name, title, and signature of the MO HealthNet enrolled provider delivering the service. Inpatient hospital services must have signed and dated physician or psychologist orders within the patient's medical record for the admission and for services billed to MO HealthNet. For patients registered on hospital records as outpatient, the patient's medical record must contain signed and dated physician
> orders for services billed to MO HealthNet. Services provided by an individual
> under the direction or supervision are not reimbursed by MO HealthNet;
> 4. The name of the referring entity, when applicable;
> 5. The date of service (month/day/year);
> 6. For those MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services American Medical Association Current Procedural Terminology procedure codes 99291–99292 and targeted case management services administered through the Department of Mental Health and as specified under 13 CSR 70-91.010 Personal Care Program (4)(A)) the actual begin and end time taken to deliver the service (for example, 4:00–4:30 p.m.) must be documented;
> 7. The setting in which the service was rendered;
> 8. The plan of treatment, evaluation(s), test(s), findings, results, and prescription(s)
> as necessary. Where a hospital acts as an independent laboratory or independent radiology service for persons considered by the hospital as "nonhospital" patients, the hospital must have a written request or requisition slip ordering the tests or procedures;
> 9. The need for the service(s) in relationship to the MO HealthNet participant's
> treatment plan;
> 10. The MO HealthNet participant's progress toward the goals stated in the treatment plan (progress notes)[.]

(Emphasis added.) Monies paid to a provider for services not verified by adequate records constitute an overpayment.[26] We examine each of the cited overpayment errors in turn.

[26] 13 CSR 70-3.130(2)(C)4.

The "Type A" Errors

Failure to use the proper code for procedure is a violation of 13 CSR 70-3.030(A)28 and 40. The Department designated as Type "A" errors instances where it found Ozarks had used improper billing codes for claims that resulted in billings for services at a higher level of service than documented in its patient records. Ozarks argues its billing codes were correct, based on the 1997 Guidelines, but, as we noted above, the 1997 Guidelines were not admitted into evidence. Consequently, Ozarks failed to prove its claims were accurately coded and billed.

Bates' testimony for the Department established the methodology she employed in analyzing the records produced by Ozarks, and the basis for its determination of Type "A" errors. We found her testimony credible, and even though Bates did not become certified in Medicaid billing until after she authored the Department's decision letter, she convincingly demonstrated her knowledge and expertise in interpreting the applicable guidelines and the medical records she reviewed in the audit. Bates' testimony addressed only a small sampling of the claims cited as Type "A" errors, but established that Ozarks' documentation supported the lowering billing code of 99213, rather than code 99214 for which Ozarks was paid. Ozarks was unable to rebut that testimony.

Ozarks failed to prove by a preponderance of the evidence that its claims designated as Type "A" errors were correctly coded. We find Ozarks violated 13 CSR 70-3.030(A)28 and 40, and that it its improper upcoding resulted in overpayment for the claims designated as Type "A" errors.

The "Type B" Errors

The Department's audit found ten Type "B" errors, indicating Ozarks' audited files lacked sufficient documentation to support billing code 99215. According to the CPT, billing code 99215 requires documentation of an office or outpatient visit that must contain at least two

of the following three components: a comprehensive history, a comprehensive exam, and medical decision making of high complexity.

Again, Ozarks' reliance on the 1997 Guidelines led it to misinterpret the CPT requirement with regard to a "comprehensive history" and "comprehensive examination," and to substitute a "simple check box analysis." Using Exhibit I as an example, the Department established, through Bates' testimony, that in one patient file, Ozarks failed to document a comprehensive history that included, among other items, a complete past, family, and social history. Moreover, the file reflected a low medical decision making complexity rather than the high complexity decision making required for CPT code 99215. These deficiencies led the Department to conclude that Ozarks' records did not support payment at the higher CPT code 99215, as billed, but at the lower billing code 99213. We agree.

In failing to use the proper billing codes, Ozarks violated 13 CSR 70-3.030(A)28 and 40, and received an overpayment for each Type "B" error. Ozarks failed to meet its burden to show the Department's audit findings as to Type "B" errors were incorrect.

The "Type C" Errors

The Department's audit found the following Type "C" errors occurred:[27]

Patient	Procedure Code	Date of Service	Net Pay	Error	Overpayment
T.A.	99214	11/11/2010	115	C	115
P.B.	99214	11/18/2010	115	C	115
P.B.	99214	12/20/2010	115	C	115
P.B.	99214	1/31/2011	115	C	115
K.B.	81003	10/28/2010	17	C	17
K.B.	99214	10/28/2010	115	C	115
K.B.	99214	11/23/2010	115	C	115
K.B.	99214	11/30/2010	115	C	115
J.L.	90658	11/18/2010	20	C	20

[27] Bates found that other "Type C" errors occurred. These errors are the ones that the parties challenge.

K.M.	99213	1/10/2011	76	C	76
K.M.	99214	2/15/2011	115	C	115
K.M.	99214	4/1/2011	115	C	115
K.M.	99213	4/7/2011	76	C	76
K.M.	99214	7/13/2011	115	C	115
K.M.	99213	7/19/2011	76	C	76
K.M.	99213	9/13/2011	76	C	76
M.S.	99214	5/11/2011	115	C	115
J.V.	90658	11/9/2010	18	C	18

The Department identified as Type "C" errors instances where Ozarks was found at the time of the review to have no documentation to support the services it billed. Services that are not properly documented cannot be billed to the Department. 13 CSR 70-3.03(3)(A)40. Thus, payments Ozarks received for such claims are overpayments.

At the hearing, Ozarks demonstrated it timely produced adequate records for services provided to patient J.V. on November 9, 2010, and to patient J.L. on November 18, 2010, in response to the Department's request. Ozarks was not overpaid for these two claims, for which it received a total of $38.

Although Ozarks failed to produce records for the remaining sixteen claims to the Department at the time of the December 12, 2012 post-payment review, it presented the records at the hearing. (Pet. Ex. 5.) The billing checklist and document disclosure statement that Ozarks' agent signed on December 12 show that Ozarks had notice of the records sought by the Department for review, and that Ozarks produced to the Department all the records requested then in its possession. Therefore, we decline to consider the records Ozarks produced at the hearing as evidence that Ozarks did not violate 13 CSR 70-3.030(3)(A)40. Were we to do otherwise, we would undermine the clear regulatory intent in 13 CSR 70-3.030(5), which requires a provider to maintain adequate documentation for the Department's review upon request. Moreover, providers may be emboldened to ignore regulations requiring that records be created contemporaneously at the time the service is provided, and attempt to prove their claims

at administrative hearings with hastily re-created – and potentially fraudulent or inaccurate – records.

Ozarks violated 13 C.S.R. § 70-3.030(3)(A)4, 7, 28, and 40 by billing for services for which it failed to maintain adequate documentation, and received overpayment for the sixteen claims identified as Type "C" errors.

The Admitted Claims

Ozarks stipulates that 111 claims were improperly billed, as alleged by the Department, and does not contest the recoupment of $4,244. The Department, after reviewing the billing records presented at the hearing, withdrew its contention that Ozarks had no documentation for five visits involving patient M.S./M.B., for which it had initially sought to recoup $575.

Recoupment

For Ozarks' violations of 13 CSR 70-3.030(3)(A)7, 28, and 40, the Department sought to impose the sanction of full recoupment of the overpayments. The imposition of sanctions is discretionary, and 13 CSR 70-3.030(5)(A) provides guidance for the exercise of that discretion:

> The following factors shall be considered in determining the sanction(s) to be imposed:
>
> 1. Seriousness of the offense(s)—The state agency shall consider the seriousness of the offense(s) including, but not limited to, whether or not an overpayment (that is, financial harm) occurred to the program, whether substandard services were rendered to MO HealthNet participants, or circumstances were such that the provider's behavior could have caused or contributed to inadequate or dangerous medical care for any patient(s), or a combination of these. Violation of pharmacy laws or rules, practices potentially dangerous to patients and fraud are to be considered particularly serious;
>
> 2. Extent of violations—The state MO HealthNet agency shall consider the extent of the violations as measured by, but not limited to, the number of patients involved, the number of MO HealthNet claims involved, the number of dollars identified in any overpayment and the length of time over which the violations occurred;

> 3. History of prior violations—The state agency shall consider whether or not the provider has been given notice of prior violations of this rule or other program policies. If the provider has received notice and has failed to correct the deficiencies or has resumed the deficient performance, a history shall be given substantial weight supporting the agency's decision to invoke sanctions. If the history includes a prior imposition of sanction, the agency should not apply a lesser sanction in the second case, even if the subsequent violations are of a different nature;
>
> 4. Prior imposition of sanctions—The MO HealthNet agency shall consider more severe sanctions in cases where a provider has been subject to sanctions by the MO HealthNet program, any other governmental medical program, Medicare, or exclusion by any private medical insurance carriers for misconduct in billing or professional practice. Restricted or limited participation in compromise after being notified or a more severe sanction should be considered as a prior imposition of a sanction for the purpose of this subsection; [and]
>
> 5. Prior provision of provider education—In cases where sanctions are being considered for billing deficiencies only, the MO HealthNet agency may mitigate its sanction if it determines that prior provider education was not provided. In cases where sanctions are being considered for billing deficiencies only and prior provider education has been given, prior provider education followed by a repetition of the same billing deficiencies shall weigh heavily in support of the medical agency's decision to invoke severe sanctions[.]

The filing of the appeal vests the Department's discretion in this Commission, but we are not required to exercise it in the same way the Department did.[28]

Ozarks failed to use proper billing codes, and billed the Department for its services at higher levels than supported by its records. While the repeated upcoding of claims resulted in payment to Ozarks for services it did not render, and caused financial harm to the MO HealthNet Program, the errors appear from the record to have arisen from Ozarks' reliance on the 1997 Guidelines, not from any intent to defraud.

The nature of the errors and the number of erroneous claims was extensive. Moreover, the lack of *any* records to support some claims violates a provider's fundamental responsibility to

[28] *Dept. of Soc. Servs. v. Mellas*, 220 S.W.3d 778 (Mo. App., W.D. 2007), at 782-83.

maintain adequate documentation. The Department presented no evidence that Ozarks had a history of prior violations or sanctions, or that Ozarks failed to receive education or training on standards for medical billing. Therefore, we find recoupment an appropriate sanction.

The record reflects Ozarks admits erroneously billing $4,244 of the $12,639 originally sought to be recouped by the Department. From the difference, $8,395, we deducted $575 for the Type "C" clams the Department conceded were properly documented for services to patient M.S./M.B., and $38 based on our finding that Ozarks timely produced records for services to patients J.V. on November 9, 2010, and to J.L. on November 18, 2010. Thus, we calculate the amount to be recouped as $7,782.

Summary

Ozarks violated 13 C.S.R. 70-3.030(3)(A)4, 7, 28, and 40, and is subject to recoupment of $7,782.

SO ORDERED on March 17, 2014.

\s\ Mary E. Nelson
MARY E. NELSON
Commissioner